DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Medical Assistance Administration
Olympia, Washington

To: Outpatient Hospitals
Managed Care Plans
Regional Administrators
CSO Administrators

Memorandum No.: 01-78 MAA
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For Information Contact:
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From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: Outpatient Hospitals - Year 2002 Changes and Additions to CPT® and HCPCS Codes

Effective for claims with dates of service on and after January 1, 2002, the Medical Assistance Administration (MAA) will begin using the Year 2002 CPT® and HCPCS Level II code additions listed in this memorandum. Additions to the maximum allowable fees for the Year 2002 are also listed.

Old Codes

Since there are a number of corrections to the existing fees, MAA is attaching an entire new fee schedule for MAA's Outpatient Hospital Services Billing Instructions, dated October 2000. This includes the new 2002 CPT® codes for therapy, laboratory, and radiology procedures. **Do not use** CPT® and HCPCS codes that are deleted in the "Year 2002 CPT®" book and the "Year 2002 HCPCS" book after December 31, 2001, dates of service.

Maximum Allowable Fees

MAA used the following resources in determining the maximum allowable fees for the Year 2002 additions:

- Year 2002 Medicare Physician Fee Schedule Data Base (MPFSDB) Relative value units;
- Year 2002 Washington State Medicare Laboratory Fee Schedule; and
- Current conversion factors.

☞ **Note:** Due to its licensing agreement with the American Medical Association regarding the use of CPT® codes and descriptions, MAA now publishes only the official brief descriptions for all codes. Please refer to your current CPT® book for full descriptions.

CPT stands for Current Procedural Terminology
HCPCS stands for Health Care Financing Administration Common Procedure Coding System

Deleted CPT® and HCPCS Codes

The following codes have been deleted from the CPT® and HCPCS books:

80072	85102	86683	88171	G0126	G0163	G0165
85095	85535	88170	93607	G0129	G0164	G0174

Procedures Requiring Written/Fax Prior Authorization

The following new procedures require **written/fax prior authorization**:

Procedure Code	Brief Description
88380	Microdissection
95965	Meg, spontaneous
95966	Meg, evoked, single
95967	Meg, evoked, each addl
0010T	Tuberculosis test, cell medi
G0231	PET WhBD colorec; gamma cam
G0232	PET WhBD lymphoma; gamma cam
G0233	PET WhBD melanoma; gamma cam
G0234	PET WhBD pulm nod; gamma cam

To obtain written/fax prior authorization, send your request to:

MAA – Medical Operations
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-2262

Radiology

- **PET Scans**

As referenced above, the following new HCPCS codes for PET scans have been added to those that require written/fax prior authorization:

Procedure Code	Brief Description
G0231	PET WhBD colorec; gamma cam
G0232	PET WhBD lymphoma; gamma cam
G0233	PET WhBD melanoma; gamma cam
G0234	PET WhBD pulm mod; gamm cam

☞ **Note:** There have been significant changes to the descriptions for **all** HCPCS PET scan codes (HCPCS codes G0030-G0047, G0125, and G0210-G0230) from the 2001 HCPCS book to the 2002 HCPCS book. Please note these significant changes to ensure proper coding of the procedure being performed.

MAA **no longer accepts the CPT® codes for PET scans** (codes 78608-78609, 78459, 78491-78492, and 78810). You must **use one of the HCPCS codes** from the range G0030-G0047, G0125, and G0210-G0234 when billing for a PET scan.

- **Outpatient MRIs**

MAA requires prior authorization for all outpatient MRIs through the Expedited Prior Authorization (EPA) process. The first six digits of the EPA number must be **870000.** The last three digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. The following chart shows the last three digits appropriate to use for the new MRI procedure:

Procedure Code	Brief Description	Last three digits of EPA Number
76394	MRI for tissue ablation	390

- **Contrast Material**

MAA covers the following new HCPCS code established for contrast material at acquisition cost for nuclear medicine procedures:

Procedure Code	Brief Description	Maximum Allowable Fee
A9511	Technetium TC 99m depreotide	Acquisition Cost

- **Technical Components of Radiology Procedures**

  In 2001, Centers for Medicare and Medicaid Services (CMS) deleted the technical (modifier TC) components of CPT® codes 76000, 93662, and 95824. However, those components are now restored. Retroactive for claims with dates of service on and after July 1, 2001, the following fees are established for these components:

Procedure Code	Brief Description	Maximum Allowable Fee
76000 TC	Fluoroscope examination	$30.70
93662 TC	Intracardiac ecg (ice)	$90.31
95824 TC	Electroencephalography	$9.86

  Effective with dates of service on and after January 1, 2002, CMS added technical components to the following radiology procedures:

Procedure Code	Brief Description	Maximum Allowable Fee
75952 TC	Endovasc repair abdom aorta	By Report
75953 TC	Abdom aneurysm endovas rpr	By Report
76012 TC	Percut vertebroplasty fluor	By Report
76013 TC	Percut vertebroplasty, ct	By Report

- **Digital Mammography**

  HCPCS codes G0203, G0205, and G0207 for digital mammograms are discontinued. These codes were used to describe the process in which the film was processed to produce a digital image that was analyzed for potential abnormalities. As an alternative, the new CPT® code 76085 is an add-on code that must be used with CPT® code 76092 to describe this process for screening mammograms.

  ☞ **Note:** Screening mammograms are reimbursed only for women 40 years of age and older. Screening mammograms are limited to one every 12 months.

- **Radiopharmaceutical Diagnostic Imaging agents**

  MAA no longer covers CPT® codes 78990 and 79900 for radiopharmaceutical diagnostic imaging agents. Use the appropriate HCPCS codes (A4641, A9500-A9700, and Q3002-Q3012) to bill for these.

Laboratory

- **Stat Lab Codes**

  The new laboratory codes are not eligible for an additional stat charge.

- **Fetal Fibronectin**

  Effective for claims with dates of service on and after January 1, 2002, MAA will begin paying for the lab procedure for fetal Fibronectin, CPT® code 82731, at a maximum allowable rate of $64.09.

- **HIV Virtual Phenotype**

  State-unique code 8999M for HIV virtual phenotype is discontinued and replaced with the following HCPCS code:

Procedure Code	Brief Description	Maximum Allowable Fee
0023T	Phenotype drug test, HIV 1	By Report

- **HIV Testing**

  The CPT® codes for HIV testing 87534, 87535, 87536, 87537, 87538, and 87539 are restricted to ICD-9 diagnoses 042 or V08.

- **Thin Layer Pap Smears**

  Retroactive for claims with dates of service on and after October 1, 2001, MAA increased the maximum allowable fee for thin-layer pap smears to match Medicare's rates. All other pap smears remain at current levels.

Procedure Code	Brief Description	Maximum Allowable Fee
88142	Cytopath, c/v, thin layer	$28.00
88143	Cytopath, c/v, thin layer redo	$28.00
88144	Cytopath, c/v, thin lyr redo	$28.00
88145	Cytopath, c/v, thin lyr sel	$28.00
88148	Cytopath, c/v, auto rescreen	$20.30

- **Lab Fees**

  A number of the lab fees were miscalculated and published incorrectly in the fee schedule replacement pages that were issued for claims with dates of service on and after July 1, 2001. Therefore, MAA is reissuing the entire fee schedule. Replacement pages to MAA's Outpatient Hospital Services Billing Instructions, dated October 2000 are attached.

☞ **Note:** Laboratory claims must include an appropriate diagnosis code. The ordering provider must give the diagnosis code to the performing laboratory at the time the tests are ordered. MAA does not reimburse a laboratory for procedures without an appropriate diagnosis code.

Wound Care Provided by Physical Therapists

Retroactive for claims with dates of service on and after January 1, 2001, MAA began reimbursing physical therapists for CPT® codes 97601 and 97602 for wound debridement. The following maximum allowable fees were established:

Procedure Code	Brief Description	Maximum Allowable Fee
97601	Wound care selective	$13.89
97602	Wound care non-selective	$13.89

These procedures are not included in the 48-unit limitation for physical therapy.

Corneal Processing

Retroactive for claims with dates of service on and after September 1, 2001, MAA increased the fee for corneal processing as follows:

Procedure Code	Description	Maximum Allowable Fee
V2785	Processing, preserving and transporting corneal tissue	$1,850.00

Coding Error for Sleep Studies

Page C.14 of MAA's Outpatient Hospital Billing Instructions, dated October 2000 (which was revised in Numbered Memorandum 01-51 MAA, dated July 2001) contains a CPT® coding error under the "Billing for Sleep Studies" heading. The third bullet should include CPT® codes **95810 and 95811** (**not** 95010 and 95011).

Attached are replacement pages C.13/C.14 and F.1-F.22 for MAA's Outpatient Hospital Services Billing Instructions, dated October 2001. To obtain this memorandum electronically, go to MAA's website at http://maa.dshs.wa.gov (Click on the Provider Publications/Fee Schedules link).